DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G022	A. BUILDING _____ B. WING _____	09/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	1026 8TH STREET NE WASHINGTON, DC 20002

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W 000	INITIAL COMMENTS The recertification survey was conducted from September 11, 2007 through September 14, 2007. The survey was initiated using the full survey process. A random sample of four clients was selected from a residential population of eight males with mental retardation and other disabilities. An additional clients was added as a focus. The survey findings were based on observations in the group home and three day programs interviews and a review of records, including unusual incident reports.	W 000		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that each client received continuous active treatment services. [See W116]	W 100		
W 104	483.410(a) (1) GOVERNING BODY	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Gorney Stephen | President | 10/19/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's governing body provided general operating directions except for the deficient practices detailed below. The findings includes: The Governing Body failed to provide continuous active treatment services. [See W196]	W 104		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of the four clients in the sample. (Clients #3 and #4) The findings includes:	W 124		

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W 124	Continued From page 2 1. During the entrance conference on September 11, 2007 at 8:00 AM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #3 received psychotropic medications for his maladaptive behavior. Observations during the medication administration at 8:50 AM revealed that Client #3 received Zyprexa 10 mg and Depakote 500 mg. Interview with the medication nurse revealed that the client received this medication for his maladaptive behaviors. During the record verification process on September 11, 2007 at 11:00 AM, it was confirmed by the client's current physician orders, that the client received the aforementioned medications. On September 13, 2007, further review of Client #3's record failed to provide evidence that written informed consent had been obtained for the use of the aforementioned medication. Continued review of Client #3's records revealed a Psychological assessment dated September 7, 2007. This assessment documented that the client had profound mental retardation and is not competent to make independent decisions regarding health, medical and financial decisions. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or legal sanction representative. 2. During the entrance conference on September 11, 2007 at 8:00 AM, the QMRP indicated that Client #4 received psychotropic medications for his maladaptive behavior. Further interview revealed that the client and has a legal guardian who signs any necessary consents for restrictive	W 124	Client # 3's guardian was appointed on January, 2007, but was reluctant to sign the consent for the use of the psychotropic medication (as she was newly assigned) at that time. However, she was made aware of the potential risk involved. On October 10, 2007, she was again asked to sign the consent for the use of psychotropic medication with the risks explained and she agreed to sign . Please see attachment A.	10-10-07

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W 124	Continued From page 3 measures. Review of the client's current physician orders revealed that the client received the following psychotropic medications: Luvox 25 mg QPM, Seroquel 100 mg QAM and Qnoon and 150 mg QPM, and Zyprexa 5 mg QPM. On September 11, 2007, further review of Client #4's record failed to show evidence that written informed consent had been obtained for the use of the medication. There was no evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client. The client's Psychological Assessment, dated December 20, 2006, indicated the client's cognitive abilities tested in the profound range of retardation and he lacked the capacity to process information effectively to make sound decisions. The psychologist had assessed the client as not being capable of making informed decisions, the facility failed to document attempts to secure an appropriate surrogate decision-maker. [See W263] 3. The facility failed to obtain consents prior to the use of sedations for a medical appointments and/or to notify the clients guardian the risks and benefits of treatments for one of the three clients in the sample. (Client #4) Review of Client #4's physician orders on September 11, 2007 at approximately 2:00 PM revealed the following sedations for medical procedures: a. On April 17, 2007, the client received Lytic Cocktail (Demerol 50 mg, Thorazine 25 mg and Phenergan 25 mg) injection one hour prior to a	W 124	Client # 4's guardian was also reluctant to sign the use of psychotropic medication form due to his new appointment on May 15, 2007. However, after consistent request and after speaking with the PMD, he agreed to sign on 10-4-07. See Attachment B	10-4-07
		W 124 3a & b	At the time the sedation was used for client # 4, a legal guardian had not yet been appointed. Therefore, the consent form used prior to the appointment of the guardian has the approval of the Human Rights Committee. All future consents for use of sedations for medical appointments will be signed by the legal guardian prior to its use.	10-19-07

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W 124	Continued from page 4 dental appointment; and b. On April 16, 2007, the client received Ativan 3 mg prior to dental appointment. During the entrance conference on September 11, 2007 at 8:00 AM, the QMRP indicated that the client has a legal guardian On September , 2007, further review of Client #4's record failed to provide evidence that written informed consent had been obtained for the use of the aforementioned medications. Continued review of Client #4's records revealed a Psychological assessment dated December 20, 2006, indicated that the client's cognitive abilities tested in the profound range of retardation and he lacked the capacity to process information effectively to make sound decisions. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or legal sanction representative. [See W263]	W 124		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents and/or guardians of significant incidents, for three of the eight clients	W 148		

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W 148	Continued From page 5 residing in the facility. (Clients #1, #3 and #4) The findings includes: Review of the facility's unusual incident reports and investigations on September 11, 2007 at approximately 10:00 AM, failed to provide evidence of the prompt notification of family members and/or guardians of the incidents detailed below: a. On February 25, 2007 at 1:20 PM staff documented that Client #1 was not feeling well and refused to eat breakfast. The staff further documented that the client had been observed to vomit "dark brownish stuff" three times. The client was subsequently taken via ambulance to the emergency room for evaluation. Review of the investigation revealed that the client was diagnosed with suspected small bowel obstruction and was hospitalized until March 1, 2007. Interview with the QMRP on September 11, 2007 at 8:45 AM revealed Client #4 did not have family, but had a legal guardian. Further review of the aforementioned incident report failed to provide evidence that Client #1's guardian had been made aware of the February 25, 2007 incident. b. On December 11, 2007, after examination by the primary care physician (PCP), Client #3 started to display seizure like activity (jerking, drooling, grinding teeth and rolling eyes). The PCP reexamined the client and Emergency Medical Services was called and the client was transported to the local emergency room. c. On February 14, 2007 at 12:45 PM, staff	W 148 W 148. Pg# 6 a. b.	QMRP had informed the Surveyor client # 1 legal guardian was appointed in May, 2007 and the incident took place in February. However, the guardian has reviewed the AMR and is aware of client's hospitalization. Attachment B1 & B2 There is an error in the date December 20077 Client # 3 has not had a seizure since his admission to DCHC in 2002.	May 2007

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W 148	Continued From page 6 reported that Client #4 was observed to exhibit jerking movements for ten seconds. The movements were classified as a seizure and the client was taken to the emergency room. Interview with the Qualified Mental Retardation Professional (QMRP) on September 11, 2007 at 8:45 AM revealed Client #4 did not have family, but had a legal guardian. Further review of the aforementioned incident report failed to provide evidence that Client #4's guardian had been made aware of the February 14, 2007 incident.	W 148	QMRP had informed the Surveyor client #4 legal guardian was appointed in May, 2007 and the incident took place in February. However, the guardian has reviewed the AMR on 10 May 2007 and is aware of client's hospitalization.	6/2007
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate each client's active treatment. The findings include: 1. The facility's QMRP failed to ensure that staff demonstrated competency in implementation of Behavior Support Plan (BSP). (See W193) 2. The facility's QMRP failed to ensure staff were adequately trained and able to demonstrate competency in the implementation of each clients Individual Program Plan. (See W194) 3. The facility's QMRP failed to ensure continuous active treatment services. (See W196	W 159	Please see answer to 193 Please see answer to 194 Please see answer to 196	

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W 159	Continued From page 7 and W249) 4. The facility's QMRP failed to ensure the participation of each client, parent or legal guardian in annual Individual Support Plan (ISP) meetings. (See W209) 5. The facility's QMRP failed to ensure objectives were developed to address self medication training program needs as identified by the interdisciplinary team (IDT) in the client's comprehensive assessment. (See W227) 6. The facility's QMRP failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) made certain that the data collection system was directly related to the outcome of the objective. (See W237) 7. The facility's QMRP failed to ensure that clients' individual program plans (IPP) included training in personal skills. (W242) 8. The facility's QMRP failed to ensure clients were provided with opportunities for choice and self-management. (See W247) 9. The facility's QMRP failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and maintained. (See W436)	W 159	Please see answer to 209 Please see answer to 227 Please see answer to W 237 Please see answer to W 242 Please see answer to W 247 Please see answer to W 436	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.	W 193		

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W 193	Continued From page 8 This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in implementation of Behavior Support Plan (BSP) for one of the four clients in the sample. (Client #4) The finding includes: The facility failed to implement Client #4's Behavior Support Plan (BSP) as written. [Also See W190]	W 193	In-service training was conducted on September 12, September, 13, 2007 and October 3, 2007 to ensure implementation of client # 4's BSP. QMRP will continue to train staff. Attachment C, 4 C 2	
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in the implementation of each clients Individual Program Plan (IPP) for one of the eight clients that resided in the facility. (Client #5) The finding includes: The facility failed to ensure staff displayed competency in implementing Client #5's diet order. On September 11, 2007 at 7:25 AM, Client #5 was observed eating a bite size breakfast which consisted of scrambled eggs, chicken patty, and toast. The client was observed to stuff six teaspoons of food into his mouth, without	W 194		

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W 194	Continued From page 9 chewing, taking a break or direct care staff intervention. At 7:05 PM, Client #5 was observed receiving a pureed dinner which consisted of chicken sandwich on a bun, vegetable soup, lettuce, tomatoes and a shake. Further observation of the client revealed no visible teeth. Interview with Qualified Mental Retardation Professional (QMRP) indicated that the client had recently had his teeth extracted and was then recommended that the client receive a pureed diet. According to the Eating - Feeding Protocol dated July 12, 2007 indicated that the client's food texture should be down graded to pureed by the primary care physician due to dental extractions and the client's rapid eating pace. The techniques included in the protocol indicated: - sit next to the client while having a meal; - prepare pureed diet; - prompts the client to alternate his liquids and solids after 2-3 bites of food; - provide verbal prompts to slow down and put ess food on spoon; - encourage napkin usage; - verbal cues to thoroughly chew his food; and - provide verbal praise when the client complies. Review of the current physician orders on September 14, 2007 at approximately 12:30 PM confirmed that the client should receive a pureed diet. There was no evidence that the facility implemented Client #5's feeding protocol.	W 194	Staff were in-serviced on proper implementation of client # 5's meal protocol, QMRP, Dietitian and Speech Pathologist will monitor the implementation of all meal time protocol. QMRP and House Manager will monitor the above on daily basis. Also QA and Program Manager will ensure that implementation of feeding protocol. Attachment 'E'	9/17/07
W 195	483.440 ACTIVE TREATMENT SERVICES	W 196		

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W 195	Continued From page 10 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure continuous active treatment services (See W196 and W249); failed to provide evidence of the participation of each client parent or legal guardian in annual Individual Support Plan (ISP) meetings,(See W209); failed to ensure objectives were developed to address self medication training program needs as identified by the interdisciplinary team (IDT) in the client's comprehensive assessment (See W227); failed to ensure that clients' individual program plans (IPP) included training in personal skills (See W242); the facility failed to ensure clients were provided with opportunities for choice and self-management (See W247); the facility failed to provide continuous active treatment (See W249); and failed to ensure data relative to the accomplishment of the criteria specified in each client's individual program plan objectives were documented in measurable terms (See W252). The effects of these systemic practices results in the failure of the facility to adequately provide active treatment services.	W 195	Please see answers to W 196; W 249; W 227; W 242; W 247; W 249; W 252.	
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:	W 196		

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W 196	Continued From page 11 (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure that clients received a continuous active treatment program for one of the four clients in the sample in accordance with recommendations made by the interdisciplinary team (IDT). (Client #4) The findings include: 1. The facility failed to implement Client #4's Behavior Support Plan (BSP) as written. A. On September 11, 2007 from 3:40 PM to 7:45 PM, the following, was observed: 3:40 PM - Client #4 was observed entering the facility with his shirt torn, exposing his chest. 4:10 PM - Client #4 was observed tearing his shirt around the neck and left sleeve. 4:18 PM - Client #4 began tearing his right underarm sleeve. The direct care staff stated to the client, "sit on your hands." The client complied with the staff directive. 4:19 PM - the direct care staff was observed tying the client's shirt into a knot at the neck-line to keep the client's chest and back from being exposed.	W 196 A. B + C	In-service training provided to staff on 09/13/07 and 10/03/07 to ensure client # 4's BSP is followed as written and that client is always well dressed. Please see Attachments C-1 & C-2 QMRP, QA and Program Manager will continue to monitor on a daily basis.	9/13/07 10/3/07

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W 196	Continued From page 12 4:20 PM - Client #4 was observed assisting direct care staff with dinner preparation. The direct care staff stepped away (approximately two feet) to put something in the trash can and the client ran upstairs to his bedroom. The staff pursued the client up the stairs. 4:22 PM - Client #4 removed the bed linens from his bed along with removing Clients #6 and #8's bed linens. 4:23 PM - Client #4 was observed to be seated on Client #5's bed. 4:25 PM - Client #4, along with a direct care staff, were observed to be seated on Client #8's bed. The client was instructed by the staff member to "sit on your hands." 4:26 PM - The direct care staff was overheard saying, "if you want to tear something, tear your shirt." The client then observed to tear his shirt. 4:30 PM - Client #4, escorted by direct care staff came downstairs without wearing a shirt. The client began to participate in tabletop activities (puzzles). 4:31 PM - Client #4 was called to the dining table to receive his afternoon snack, without wearing a shirt. Client #4 was without a shirt for 1 hour 55 minutes. B. Interview with the direct care staff on September 11, 2007 at 5:55 PM, revealed that Client #4 has a behavior of tearing his shirts and sometimes his pants. The client must be monitored at all times, to avoid his behavior of	W 196		

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D C HEALTH CARE	1026 8TH STREET NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 13 shirt tearing. When the client displays this behavior staff should provide the client with another shirt, although the client will tear it again. At 6:06 PM, the direct care staff provided the client with a shirt. C. Review of Client #4's Behavior Support Plan (BSP) dated February 20, 2007 verified that the client had the targeted behavior of clothes ripping. According to the BSP, the direct care staff should demonstrate the following strategies: - Involve the client in activities which involve constructive use of his hands; - Praise him with social praise; - Once the client displays the maladaptive behavior - the direct care staff say, "[the client] do not tear your shirt and put your hand down; and - Immediately provide the client with another article of clothing. Observations of this behavior during the survey failed to provide evidence that Client #4's BSP was being implemented as outlined. 2. On September 11, 2007 during evening observations from 3:40 PM through 7:30 PM, Client #4 was observed participating in table top activities (puzzles). Once the client put a puzzle piece in place, the client was observed hitting his chest or banging on the table. Interview with the direct care staff and Qualified Mental Retardation Professional (QMRP) on September 12, 2007 at approximately 11:00 AM revealed that the client had a BSP to address the	W 196	2. Staff in-service training on the current Behavior Support Plan was conducted on October 3, 2007. Follow-up training will be conducted as needed. Both the Psychologist and the QMRP will continue to monitor staff and give additional training as needed. QA & Program Manager will also monitor the above on routine basis.	10/3/07

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W 196	Continued From page 14 client's chest hitting. Review of the BSP dated February 22, 2007 revealed a program objective which stated, "[the client] will reduce the frequency of chest hitting to 20 reports per month for six months. According to the BSP, the direct care staff should demonstrate the following strategies: - Involve the client in activities which involve constructive use of his hands; - Praise him with social praise and staff should clap their hands when praising the client. - the client will be trained to clap his hand when he has done a good job; - Once the client displays the maladaptive behavior - the direct care staff say, "No [the client] do not hit your chest. Instruct the client to clap his hands. Provide verbal prompts to hands on hand assistance as needed; and - Continue to reinforce the client for appropriate behavior throughout the day. Observations of this behavior during the survey failed to provide evidence that Client #4's BSP was being implemented as outlined. 3. The facility failed to implement Client #4's speech program as written. On September 11, 2007 during evening observations from 3:40 PM through 7:30 PM, Client #4 was observed participating in table top activities (puzzles). Once the client put a puzzle piece in place, the client was observed hitting his	W 196	An in-service was done by Speech Pathologist on 10/01/07 on American Sign Language and communication goal of client # 4. QMRP will ensure the proper implementation of individual communication goal. Attachment E	10-1-07

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W 196	Continued From page 15 chest or banging on the table. Interview with the direct care staff and Qualified Mental Retardation Professional (QMRP) on September 12, 2007 at approximately 11:00 AM revealed that the client had a speech program to produce American sign language (ASL): good, drink, finished and game. The ASL "good" should be implemented as opposed hitting his chest or banging on the table. Review of the clients Individual Program Plan (IPP) dated February 2, 2007 revealed an objective which stated, "[the client] will produce four ASL sings "good, etc... with 80% independence in one year December 2007. There was no evidence that the direct care staff implemented the strategies for Client #4's speech program objective. 4. The facility failed to implement Client #4's activities of daily living skills. a. On September 11, 2007 at 4:31 PM, direct care staff was observed putting Client #4's snack utensil in the kitchen sink. At 7:21 PM, direct care staff was again, observed putting the client's dinner plate, cup and utensils in the sink. Interview with the direct care staff indicated that the client should be kept busy to avoid shirt tearing. Record review of the IPP dated February 2, 2007, Client #4 has a program objective which states, "[the client] will place dinner ware to the kitchen sink on 80% of the trials recorded per month for three consecutive months. b. On September 11, 2007 during evening	W 196	Client # 4 IPP goals and objectives will be implemented as written. Staff in-service was done on 10/02/07 to ensure consistent implementation of his programs. Above will be supervised by See Attachment F	

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W 196	Continued From page 16 observations, the direct care staff was observed wiping the table, after both the snack and dinner meal. Interview with the direct care staff indicated that the client should be kept busy to avoid shirt tearing. Record review of the IPP dated February 2, 2007, Client #4 has a program objective which states, "[the client] will wipe the table on 80% of the trials recorded per month for three consecutive months. There was no evidence that the facility encouraged Client #4 to participate in activities of daily living skills.	W 196		
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence of the participation of each client parent or legal guardian in annual Individual Support Plan (ISP) meetings, for two of the four clients included in the sample. (Client #2 and #3) The findings include: 1. The facility failed to provide evidence that Client #2 attending his ISP meeting. Review of Client #2's records on September 12, 2007 at 7:13 PM revealed the client's ISP meeting was held on October 2, 2006. Further review of	W 209		

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W 209	Continued from page 17 the ISP document failed to provide evidence that the client and/or his legal guardian had signed the ISP attendance form. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on September 13, 2007 to ascertain if the client attended his meeting. The QMRP indicated that the client was at the meeting, but the attendance form was not signed indicating that fact. At the time of the survey, the facility failed to provide evidence that Client #2 attended his ISP meeting. 2. The facility failed to provide evidence of persons in attendance at Client #3's ISP meeting. Review of the Client #3's comprehensive functional assessments on September 12, 2007 at 12:30 PM failed to provide evidence of a sign-in sheet to determine who participated in the client's ISP meeting held on September 7, 2007.	W 209 1. 2.	Client # 2/his mother (who is also his legal guardian) case manager and attorney all attended his ISP meeting. Please see attachment G1, G2 & G3 The ISP document for client # 3 was not yet in the file but the Surveyor was provided with all assessments along with the sign in sheets for review. The ISP was held on 09/07/07. Attachment H1 & H2	10/2/06 9/7/07
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on interview with the observation, staff interview and record review, the facility failed to ensure that an objectives was developed to address self medication training program need as identified by the interdisciplinary team (IDT) in the comprehensive assessment for four of the four clients in the sample. (Clients #1, #2, and #3) The findings includes:	W 227		

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W 227	Continued from page 18 1. On September 11, 2007 at 8:50 AM, Client #3 was observed being administered his medications. The Licensed Practical Nurse (LPN) prepared the client's medications, poured a cup of water and gave the client the medication and water cup. The client consumed the medications and the water. Interview with the LPN indicated that the client participates in a self medication program. Review of the self medication assessment dated August 7, 2006 indicated that the client would benefit from a modified version of a self medication program. Review of the IPP dated September 7, 2007 revealed no program goal or objective for the client to receive training in self medication. A data sheet was in the Medication Administration Record (MARs) book which included steps in which the client should perform during the medication administration. The IPP failed to identified program objective in this area. 2. Review of Client #4's records on September 13, 2007 at 2:00 PM revealed the client's Self-Medication Assessment dated January 3, 2007. According to the assessment, the client was recommended to participate in a self-medication program, but the specific goal and corresponding program objective was not documented on the assessment. Interview with the Qualified Mental Retardation Professional (QMRP) and further record review on September 13, 2007 at 3:00 PM revealed Client #4's IPP dated July 7, 2007. Review of the plan and discussion with the QMRP failed to provide evidence of an objective written to assist the	W 227	As of 09/14/07, client # 3's self medication program was included in the individual program plan record. QA will monitor to ensure that all objectives are identified in the IPP. QA will monitor to ensure that all objectives are identified in the IPP. As of 09/14/07 , client # 4's self medication program was included in the individual program plan record. QA will monitor to ensure that all objectives are identified in the IPP.	9/14/07 9/14/07

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W 227	Continued From page 19 client with acquiring skills in the domain of self-medication administration. 3. Observation of the morning medication administration on September 11, 2007 at 8:30 AM revealed the LPN prepared Client #1's medication and poured the client some water to drink. The LPN gave the client the medication and the cup of water. The client complied with taking his medication. The client was then observed to throw the cup into the trash can. Interview with the LPN indicated that the client participates in a self medication program. Review of Client #1's records on September 13, 2007 at 5:30 PM revealed the client's Self-Medication Assessment dated May 2, 2007. According to the assessment, the client was recommended to participate in a self-medication program, but the specific goal and corresponding program objective was not documented on the assessment. Interview with the Qualified Mental Retardation Professional (QMRP) and further record review on September 13, 2007 at 5:36 PM revealed Client #1's IPP dated July 7, 2007. Review of the plan and discussion with the QMRP failed to provide evidence of an objective written to assist the client with acquiring skills in the domain of self-medication administration. 4. Observation of the morning medication administration on September 11, 2007 at 8:43 AM, revealed the LPN prepared Client #2's medication and poured the client some water to drink. The LPN gave the client his medication and the cup of water. The client complied with taking his medication. The client was then observed to throw the cup into the trash can. Interview with the LPN indicated that the client	W 227	As of 09/14/07, client # 1's self medication program has been included in the client's IPP. QA will monitor to ensure that all objectives are identified in the IPP. Self Medication Program for client # 2 has been included in IPP as of 09/14/07. QA will monitor to ensure that all objectives are identified in the IPP.	

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W 227	Continued From page 20 participates in a self medication program. Review of Client #2's records on September 12, 2007 at 6:27 PM revealed the client's Self-Medication Assessment dated October 2, 2006. According to the assessment, the client was recommended to participate in a self-medication program, but the specific goal and corresponding program objective was not documented on the assessment. Interview with the QMRP and further record review on September 12, 2007 at 7:40 PM revealed Client #2's IPP dated October 2, 2006. Review of the plan and discussion with the QMRP failed to provide evidence of an objective written to assist the client with acquiring skills in the domain of self-medication administration.	W 227		
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) made certain that the data collection system was directly related to the outcome of the objective for one of the three clients (Client #1) included in the sample. The findings includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #1's	W 237		

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W 237	Continued from page 21 record on September 13, 2007 at 5:36 PM revealed the client had an IPP dated July 7, 2007. Review of the IPP revealed the client participated with several program objectives including the following: Client #1 will participate in all of the Special Olympics activities with reminders at a rate of 80% (unified bowling league, winter games, and summer games). Continued interview with the QMRP and review of the client's program data record on September 14, 2007 revealed the corresponding data collection form for the aforementioned program. Review of the data collection form revealed that the form was design to document various recreational activities in which the client participated. The form appeared to be generic as it did not specify a goal or objective for the client, although, there was an area for which that information could have been documented. Interview with the QMRP revealed that the form was designed to document all recreational activities in which the client participated, not solely the aforementioned program. At the time of the survey, the facility failed to ensure Client #1's recreational program data collection form was designed to accurately collect data related to his program objective.	W 237	As of 09/14/07, a skill sheets have been designed to document specific Special Olympic objective for client # 1 Recreation . See Attachment 1	9/14/07
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication	W 242		

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W 242	Continued From page 22 of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills, for one of the four clients (Client #1) included in the sample. The findings includes: The facility failed to ensure Client #1 received training to address privacy when using the bathroom. Observation on September 11, 2007 at 4:20 PM revealed Client #1 in the bathroom, located in his bedroom. The client was observed standing in front of the toilet with his pants and undergarments down, exposing his genitals. It should be further noted that the bathroom and bedroom doors were wide open. Interview was conducted with staff on September 11, 2007 at 9:52 AM regarding the client's current learning objectives and did not reveal any evidence that the client was receiving any training in privacy while using the bathroom. Review of Client #1's IPP (dated July 7, 2007) on September 13, 2007 at 5:36 PM failed to provide evidence of a training objective to assist the client with maintaining his privacy while using the bathroom. At the time of the survey, the facility failed to ensure Client #1 received privacy training.	W 242	Staff in-service was done on 10/02/07 by the social worker to stress the importance of supervision and the clients privacy issues. QMRP and QA QA will continue to monitor and supervise staff. Privacy training was done by the Nursing Director on 10/10/07 to emphasize the importance of assisting individuals in maintaining privacy. Training was done with both clients and staff. Attachment J	10-2-07
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN	W 247		

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W 247	Continued From page 23 The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interviewed review, the facility failed to ensure clients were provided with opportunities for choice and self-management, for four out of four clients (Clients #1, #2, #3, and #4) included in the sample The findings includes: The facility failed to ensure clients were given the opportunity to make a choice regarding their eating utensils. Observation of the evening meal on September 12, 2007, beginning at 6:37 PM revealed the clients seated at for the table eating their meal. The dinner consisted of turkey, cabbage, sweet potatoes, corn bread, milk, water and fruit cocktail for dessert. Further observation of the table setting revealed that spoons were the only utensils given to the clients (Clients #1, #2, #3, and #4). The Qualified Mental Retardation Professional (QMRP) was interviewed after the meal to ascertain information regarding the practice of giving the clients spoons only. The QMRP further revealed that there was no reason for the clients to receive spoons only and usually indicated that they were usually provided additional utensils. At the time of the survey, the facility failed to ensure clients were given a choice regarding their eating utensils.	W 247	Staff was in-serviced on 09/17/07 emphazing the importance of providing all utensils during mealtime set-up which allows the clients to exercise choice in the type of utensils they would like to use. QMRP and House Manager will monitor on daily basis. QA and Program Manager will oversee on a routine basis. See Attachment K	9/17/07
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 24 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to provide continuous active treatment for three of the four clients in the sample. (Clients #1, #3 and #4) The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on September 11, 2007 at 8:45 AM revealed Client #1 was prescribed psychotropic medications and had a Behavior Support Plan (BSP) to address maladaptive behaviors. Review of the BSP (dated July 25, 2007) on September 13, 2007 at 5:34 PM revealed the plan had the following two program objectives: - Client #1 will display no more than 15 reports of verbal aggression per month for 6 months. - Client #1 will display no more than three occurrences of physical aggression (hitting others or objects) per month for 6 months. Further review of the plan revealed the plan incorporated the use of a report card system.	W 249		

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W 249	Continued From page 25 According to the BSP, Client #1 would review the report card every two hours with his primary counselor and the counselor would document the client's progress as it related to exhibiting any of the aforementioned targeted behaviors. For example, staff were required to ask the client the following questions every two hours: - Client #1 did you keep your hands to yourself? - Client #1 did you talk politely? - Client #1 did you respect others property? After the client responded to the questions (yes or no), staff would document either a 1 (referring to yes) of 0 (referring to no) onto the report card. The report card was scheduled to be completed from 4:00 PM to 9:00 PM weekdays and 7:00 AM to 9:00 PM on the weekends. If Client #1's report card documented 1's for at least 80% of the documentation on the previous day, the client was to receive "a magazine of his choice, a trip to a favorite place for a movie, shopping, etc...). Further review of the data collection record revealed there had been no documentation of Client #1's report card after August 31, 2007. It should be further noted that staff were not observed to utilize the report card system during the survey. At the time of the survey, the facility failed to provide evidence that Client #1's BSP was being implemented as outlined. 2. The facility failed to implement Client #4's speech program as written. On September 11, 2007 during evening observations from 3:40 PM through 7:30 PM, Client #4 was observed participating in table top activities (puzzles). Once the client put a puzzle piece in place, the client was observed hitting his	W 249	1. Staff in-service training was conducted on October 3, 2007. Follow-up training will be conducted as needed. Both the Psychologist and QMRP will observe staff to determine if they are implementing the Behavior Support Plan as outlined, staff will be informed of appropriate support steps. Please see attachment C-3 2. An in-service was done by Speech Pathologist on 10/01/07 on American Sign Language and communication goal of client # 4. QMRP will ensure the proper implementation of individual communication goal. QA will monitor. Please see Attachment E	10/3/07 10/1/07

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W 249	Continued From page 26 chest or banging on the table. Interview with the direct care staff and Qualified Mental Retardation Professional (QMRP) on September 12, 2007 at approximately 11:00 AM revealed that the client had a speech program to produce American sign language (ASL): good, drink, finished and game. The ASL "good" should be implemented as opposed hitting his chest or banging on the table. Review of the clients Individual Program Plan (IPP) dated February 2, 2007 revealed an objective which stated, "[the client] will produce four ASL sings "good, etc... with 80% independence in one year December 2007. There was no evidence that the direct care staff implemented the strategies for Client #4's speech program objective. 3. The facility failed to implement Client #4's activities of daily living skills. a. On September 11, 2007 at 4:31 PM, direct care staff was observed putting Client #4's snack utensil in the kitchen sink. At 7:21 PM, direct care staff was again, observed putting the client's dinner plate, cup and utensils in the sink. Interview with the direct care staff indicated that the client should be kept busy to avoid shirt tearing. Record review of the IPP dated February 2, 2007, Client #4 has a program objective which states, "[the client] will place dinner ware to the kitchen sink on 80% of the trials recorded per month for three consecutive months. b. On September 11, 2007 during evening	W 249 3. a.	Client # 4 IPP goals and objectives will be implemented as written. Staff in-service was done on 10/02/07 to ensure consistent implementation of his programs. See Attachment F	10/2/07

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W 249	Continued From page 27 observations, the direct care staff was observed wiping the table, after both the snack and dinner meal. Interview with the direct care staff indicated that the client should be kept busy to avoid shirt tearing. Record review of the IPP dated February 2, 2007, Client #4 has a program objective which states, "[the client will wipe the table on 80% of the trials recorded per month for three consecutive months. There was no evidence that the facility encouraged Client #4 to participate in activities of daily living skills.	W 249 3 · b ·	An in-service was done by Speech Pathologist on 10/01/07 on American Sign Language and communication goal of client # 4. QMRP will ensure the proper implementation of individual communication goal. QA will monitor. Please see Attachment E	10/1/07
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure data relative to the accomplishment of the criteria specified in each client's individual program plan objectives were documented in measurable terms, for one of the four clients (Client #1) included in the sample. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on September 11, 2007 at 8:45 AM revealed Client #1 was prescribed psychotropic medications and had a Behavior Support Plan (BSP) to address maladaptive	W 252		

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W 252	Continued from page 28 behaviors. Review of the BSP (dated July 25, 2007) on September 13, 2007 at 5:34 PM revealed the plan had the following two program objectives: - Client #1 will display no more than 15 reports of verbal aggression per month for 6 months. - Client #1 will display no more than three occurrences of physical aggression (hitting others or objects) per month for 6 months. Further review of the plan revealed the plan incorporated the use of a report card system. According to the BSP, Client #1 would review the report card every two hours with his primary counselor and the counselor would document the client's progress as it related to exhibiting any of the aforementioned targeted behaviors. For example, staff were required to ask the client the following questions every two hours: 1. Client #1 did you keep your hands to yourself? 2. Client #1 did you talk politely? 3. Client #1 did you respect others property? After the client responded to the questions (yes or no), staff would document either a 1 (referring to yes) of 0 (referring to no) onto the report card. The report card was scheduled to be completed from 4:00 PM to 9:00 PM weekdays and 7:00 AM to 9:00 PM on the weekends. Review of the data collection record revealed there had been no documentation of Client #1's report card after August 31, 2007. Additional review of the client's data collection record revealed the documentation collected from May 2007 through August 31, 2007 failed to be documented as outlined in the plan (there were no 1's or 0's documented). At the	W 252	To reinforce BSP as written, staff was in-serviced on the current behavior support plan of client # 1. Psychologist and the QMRP will monitor and observe staff to ensure full and proper implementation of the prescribed plan. See in-service sheets. Attachment # C-3	

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W 252	Continued From page 29 time of the survey, the facility failed to ensure data collected for Client #1's BSP (report card) was collected in the form outlined by the plan.	W 252		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for three of four clients in the sample (Clients #1, #3 and #4). The findings include: 1. The facility failed to obtain informed consent prior to the use of restrictive measures as described in Clients #3 and #4's Behavior Support Plan. [See W124, 1 and 2] 2. The facility failed to ensure that informed consent was obtained prior to the administration of sedations for Client #4. [See W124, 3] 3. Interview with the Qualified Mental Retardation Professional (QMRP) on September 11, 2007 at 8:45 AM and review of Client #2's record on September 12, 2007 at 7:42 PM the client utilized a Behavior Support Plan (BSP) to address maladaptive behaviors (self injurious behaviors	W 263 1 2	Please see answer to W 124, 1 and 2 Please see W 124 - 3	

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W 263	Continued from page 30 and physical aggression). Further review of the plan dated February 20, 2007 revealed the plan incorporates the use of restrictive techniques (i.e. assisting the client to a new area in instances when aggressive behaviors are displayed and physical prompting to address SIB). It should be noted that additional interview with the QMRP on September 11, 2007 revealed Client #2 does not possess the capacity to give informed consent for the use of his medications and habilitation services. Additionally, the QMRP failed to provide evidence of a legal guardian to assist the client in making decisions. Review of Client #2's record verified the QMRP's statement regarding the client's capacity to give consent. The client's psychological assessment dated September 25, 2006, reviewed on September 12, 2007 at 6:[illegible] PM documented that Client #2, "does not display the capacity to make decisions on his own behalf regarding his treatment/habilitation, ongoing medical care, residential placement, and financial matters." At the time of the survey, the facility failed to provide evidence that its Human Rights Committee had obtained written informed consent for the use of Client #2's behavior support plan.	W 263	Client #2 BSP was approved by Human Rights Committee February 22, 2007. The intent of the program - taking him to another area of the room was not restrictive in nature but reviewed as a safety mechanism to prevent injury to the client as well as his peers. See Attachment L-1 & 2	
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.	W 264		

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W 264	Continued From page 31 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide evidence that its Human Rights Committee (HRC) thoroughly monitored and made suggestions about the facility's practice of pad locking the freezer, for one of the eight clients (Client #7) that resided in the facility The findings includes: Observation on September 11, 2007 at 8:23 AM revealed Client #7 from the kitchen, through the dining room, into the living room. The client mouth was observed to be stuffed with bread. Observation of the kitchen environment, directly after the aforementioned incident, revealed one loaf of bread (little less than half a loaf) was on top of the large freezer. The freezer in the kitchen was observed to be locked. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) and one staff member on September 11, 2007 at 8:31 AM to ascertain information about why the freezer was locked. It was revealed that the freezer was locked to prevent unnecessary items from being removed. Additionally, it was revealed that Client #7 was known to grab food. The QMRP was further interviewed to determine if the facility's practice of locking the freezer had been reviewed and approved by their HRC, and at the time of the survey, there was no evidence provided that revealed the aforementioned practice had been approved	W 264	The large freezer is used for extra food storage. The practice of locking the freezer as a safety measure will be discussed at the next HRC Meeting to be held on November 14, 2007. The Fridge in the kitchen holds more than adequate food for weekly use.	11/14/07
W 331	483.460(c) NURSING SERVICES	W 331		

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W 331	Continued From page 32 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of four clients in the sample (Clients #1 and #3) The findings include: 1. The facility's nurse failed to ensure that the health status was reviewed by the Registered Nurse (RN) on a quarterly or more frequent basis. [See W336] 2. The facility's nurse failed to ensure that the Client received all prescribed medications without error. [See W369] 3. The facility's nurse failed to ensure clients are taught to administer their own medications. [See W371]	W 331	Please see Answer to W 336 Please see Answer to W 369 Please see Answer to W 371	
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a health status was reviewed by the nursing staff on a quarterly or more frequent basis for two of the four clients in the	W 336		

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W 336	Continued From page 33 facility. (Clients #1 and #3) The finding includes: 1. Interview with the facility's Licensed Practical Nurse (LPN) on September 13, 2007 revealed that the Registered Nurse completes quarterly nursing exams. Review of the Client #4's medical record revealed that a nursing assessment was completed on January 3, 2007. Further review of client's medical record failed to evidence that a quarterly health status had been completed for the first quarterly review period (April 12, 2007). 2. Interview with the facility's nurse on September 13, 2007 revealed that the Registered Nurse was responsible for completing quarterly assessments of the clients. Review of Client #1's medical record on September 11, 2007 at 4:15 PM revealed the client's annual nursing assessment was conducted on May 2, 2007. Further review of the client's record revealed that there was no quarterly assessment in the record after the date of the assessment through the survey time period.	W 336	1. Unfortunately, the QMRP had not filed the nursing quarterly in a timely manner. A copy of the nursing quarterly was retrieved from the office and filed on the same day, September 13, 2007. The surveyor was made aware. 2. Client # 1 was hospitalized from July 6-July 27, 2007. During this period, daily nursing notes were being written instead of a quarterly report. Quarterly report was completed by Nursing Staff and filed on 09/17/07. DCHC will ensure that nursing quarterlies are filed in timely manner.	9/13/07 9/17/07
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, and record review, the facility failed to ensure that the Client received all prescribed medications without error for one of the four clients in the sample. (Client #1) The finding includes:	W 369		

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W 369	Continued From page 34 Observation of the medication administration on September 11, 2006 at 8:30 AM, Client #1 was administered Lorazepam 0.5 mg, Multivitamin, Norvasc 2.5 mg, Aspirin 81 mg, Calcium Carbonate 10 gr, Proscar 5 mg and Buspar 5 mg. Record review of the medication administration records (MARs) and the physician orders indicated that the client should have received in addition to aforementioned medications, Vitamin C. Interview with the Licensed Practical Nurse (LPN) indicated that the primary care physician discontinued the medication. According to the current physician orders dated September 2007 revealed that the Vitamin C was on the current orders.	W 369	Client # 1 medication Vitamin C was discontinued on 08/17/07 as per the Physician's order. It was on the current order because PO is computer generated and it takes time to delete the same from the system. However, it was struck off by hand on 08/17/07. Attachment - M	
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients are taught to administer their own medications, for four of the four clients (Clients #1, #2, #3, and #4) included in the sample. The findings includes: The facility failed ensure clients were trained to administer their own medications. (See W227)	W 371		
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436		

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W 436	Continued from page 35 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and maintained for two of four clients included in the sample. (Clients #2 and #5) The findings include: 1. Observation of the evening meal on September 11, 2007 and September 12, 2007 revealed the client received his meal on a regular plate. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the client's Occupational Therapy Assessment (dated December 13, 2006) on September 12, 2007 at 12:21 PM revealed the consultant recommended the client use a sectional plate when eating to increase his ability with identifying his food. The QMRP was interviewed on September 14, 2007, to ascertain information regarding the client's recommended sectional plate. The QMRP revealed that the plate was being ordered. At the time of the survey, the facility failed to ensure Client #2 had the recommended sectional plate to utilize during meals.	W 436	1. 4 2. DCHC will make sure that all recommendations are implemented and will ensure to replace/order equipments in timely manner. Sectional plate and dycem mat was received on 9/15/07. DCHC will ensure that eating protocols and precautions are followed by the staff. QMRP will continue staff training and monitor the proper implementation of the eating protocol.	9/15/07

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W 436	Continued From page 36 2. On September 11, 2007 during meal observations at the residential facility, Client #5 was observed using a plate guard. The dinner plate was observed moving around on the table top. Interview with the Qualified Mental Retardation Professional (QMRP) on September 13, 2007 revealed that the dycem plate had been damaged. Further interview with the Administrator According to the eating feeding protocol dated July 11, 2007 revealed that the client needs a dycem mat and plate guard. There was no evidence that the facility provided Client #5 with the appropriate adaptive feeding equipment as recommended.	W 436		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to provide the prescribed texture diet for one of the eight clients residing in the facility (Client #5) The findings includes: On September 11, 2007 at 7:25 AM, Client #5 was observed eating a bite size breakfast which consisted of scrambled eggs, chicken patty, and toast. The client was observed to stuff six teaspoons of food into his mouth, without direct care staff intervention. At 7:05 PM, Client #5 was observed receiving a	W 474	Client # 5 food was to be pureed it was an error on part of the staff. Staff has been trained on 09/17/07 to follow the prescribed diet/texture order. Attachment D	9/17/07

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W 474	Continued From page 37 pureed dinner (chicken sandwich on a bun, vegetable soup, lettuce and tomatoes). Further observation of the client revealed no visible teeth. Interview with Qualified Mental Retardation Professional (QMRP) indicated that the client had recently had his teeth extracted and was then recommended that the client receive a pureed diet. According to the eating feeding protocol dated July 11, 2007 revealed a 2500 calorie, double portions, pureed diet. Review of the client's current physician orders confirmed the pureed diet.	W 474		

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I 000	INITIAL COMMENTS The recertification survey was conducted from September 11, 2007 through September 14, 2007. A random sample of four residents was selected from a residential population of eight males with mental retardation and other disabilities. The survey findings were based on observations in the group home and three day programs interviews and a review of records, including unusual incident reports.	I 000		
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that modified diets were served as prescribed, for one of the four residents (Resident #5) that resided in the facility. The finding includes: On September 11, 2007 at 7:25 AM, resident #5 was observed eating a bite size breakfast which consisted of scrambled eggs, chicken patty, and toast. The resident was observed to stuff six teaspoons of food into his mouth, without direct care staff intervention. At 7:05 PM, Resident #5 was observed receiving a pureed dinner (chicken sandwich on a bun, vegetable soup, lettuce and tomatoes). Further observation of the resident revealed no visible	I 042		

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I 042	Continued From page 1 teeth. Interview with Qualified Mental Retardation Professional (QMRP) indicated that the resident had recently had his teeth extracted and was then recommended that the resident receive a pureed diet. According to the eating feeding protocol dated July 11, 2007 revealed a 2500 calorie, double portions, pureed diet. Review of the resident's current physician orders confirmed the pureed diet.	I 042	Staff ~~is~~ were in-serviced on proper implementation of client # 5's meal protocol, QMRP, Dietitian and Speech Pathologist will monitor the implementation of all meal time protocol. QMRP and House Manager will monitor the above on daily basis. Also QA and Program Manager will ensure that implementation of feeding protocol. Attachment "D"	9/17/07
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans. The findings includes: 1. The facility failed to provide continuous active treatment services. [See Federal Deficiency Report Citation W104, W195, W196, and W249] 2. The facility failed to ensure that its Qualified Mental Retardation Professional (QMRP) adequately monitored, integrated, and coordinated each resident's active treatment program [See Federal Deficiency Report Citation W159]	I 180	Please see answer to W104, W195, W196 and W249. Please see answer to W159.	

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I 229	Continued From page 2	I 229		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure staff were effectively trained on each resident's dietary plan and behavior support plan for two of the eight residents (residents #4 and #5) in the facility. The findings include: 1. The facility failed to ensure staff displayed competency in implementing Resident #5's diet order. On September 11, 2007 at 7:25 AM, Resident #5 was observed eating a bite size breakfast which consisted of scrambled eggs, chicken patty, and toast. The resident was observed to stuff six teaspoons of food into his mouth, without chewing, taking a break or direct care staff intervention. At 7:05 PM, Resident #5 was observed receiving a pureed dinner which consisted of chicken sandwich on a bun, vegetable soup, lettuce, tomatoes and a shake. Further observation of the resident revealed no visible teeth. Interview with Qualified Mental Retardation Professional (QMRP) indicated that the resident had recently had his teeth extracted and was then	I 229	Staff were in-serviced on proper implementation of client #5's meal protocol, QMRP, Dietician and Speech Pathologist will monitor the implementation of all meal time protocol. QMRP and House Manager will monitor the above on daily basis. Also QA and Program Manager will ensure that implementation of feeding protocol. Attachment 'D'	9/17/07

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I 229	Continued From page 3 recommended that the resident receive a pureed diet. According to the Eating - Feeding Protocol dated July 12, 2007 indicated that the resident's food texture should be down graded to pureed by the primary care physician due to dental extractions and the resident's rapid eating pace. The techniques included in the protocol indicated: - sit next to the resident while having a meal; - prepare pureed diet; - prompts the resident to alternate his liquids and solids after 2-3 bites of food; - provide verbal prompts to slow down and put less food on spoon; - encourage napkin usage; - verbal cues to thoroughly chew his food; and - provide verbal praise when the resident complies. Review of the current physician orders on September 14, 2007 at approximately 12:30 PM confirmed that the resident should receive a pureed diet. There was no evidence that the facility implemented Resident #5's feeding protocol. 2. See Federal Deficiency Report - Citation W193	I 229		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and	I 374		

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I 374	Continued From page 4 documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents for three of the eight residents in the facility. (Residents #1, #3, and #4) The finding includes: See Federal Deficiency Report - Citation W148	I 374	Medical guardians of clients 1, # 3 and #4 were appointed in May and incident took place in February. Medical guardians have reviewed the AMR and are aware of their clients incidents. See Attachment A Please see answer to W148.	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was immediately notified of unusual incidents that substantially interfered with a resident's health, for two of the four residents (Residents #1 and #4) included in the sample. The finding includes:	I 379	DCHC will make sure that all notifications of unusual incidents are reported to the DOH as required by law.	10-23-07

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I 379	Continued From page 5 Review of the facility's unusual incident reports and investigations on September 11, 2007 at approximately 10:00 AM, revealed the facility failed to immediately notify the Department of Health of the following incidents as required: a. On February 25, 2007 at 1:20 PM staff documented that Client #1 was not feeling well and refused to eat breakfast. The staff further documented that the client had been observed to vomit "dark-brownish stuff" three times. The client was subsequently taken via ambulance to the emergency room for evaluation. Further review of the incident report revealed that the Department of Health was initially notified of the aforementioned incident on February 26, 2007. It should be noted that review of the investigation revealed that the client was diagnosed with suspected small bowel obstruction and was hospitalized until March 1, 2007. b. On February 14, 2007 at 12:45 PM, staff reported that Client #4 was observed to exhibit jerking movements for ten seconds. The movements were classified as a seizure and the client was taken to the emergency room. Further review of the incident report revealed the facility notified the Department of Health on February 15, 2007.	I 379 a & b	DCHC will make sure that all notifications of unusual incidents are reported to DOH as required by law. An in-service training is scheduled for all QMRP's and administrative staff on incident reporting on 10/23/07.	10-23-07
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The	I 395		

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I 395	Continued From page 6 professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure its nurses had current licenses on file. The finding includes: Review of the personnel records on September 12, 2007 revealed the GHMRP failed to have current license on file for one licensed practical nurse.	I 395		
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons' (GHMRP), failed to provide evidence of a nursing and nutrition quarterly reports two of the four residents in the sample. (Residents #1 and #3) The finding includes: See Federal Deficiency Report - Citation W336	I 407	Unfortunately, the QMRP had not filed the nursing quarterly in a timely manner. A copy of the nursing quarterly was retrieved from the office and filed on the same day, September 17, 2007. The surveyor was made aware. Client # 1 was hospitalized from July 6-July 27, 2007. During this period, daily nursing notes were being written instead of a quarterly report.	9-17-07

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I 422	Continued From page 7	I 422		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s). The findings includes: I. The facility failed to ensure Resident #4 received a continuous active treatment program by making certain the client's Behavior Support Plan (BSP) was implemented as written. A. On September 11, 2007 from 3:40 PM to 7:45 PM, the following, was observed: 3:40 PM - Resident #4 was observed entering the facility with his shirt torn, exposing his chest. 4:10 PM - Resident #4 was observed tearing his shirt around the neck and left sleeve. 4:18 PM - Resident #4 began tearing his right underarm sleeve. The direct care staff stated to the client "sit on your hands." The resident complied with the staff directive. 4:19 PM - the direct care staff was observed tying the client's shirt into a knot at the neck-line to keep the client's chest and back from being exposed. 4:20 PM - Resident #4 was observed assisting	I 422 A B + C	In-service training provided to staff on 09/13/07 and 10/03/07 to ensure client # 4's BSP is followed as written and that client is always well dressed. Please see Attachments C-1 & C-2 QMRP, QA and Program Manager will continue to monitor on a daily basis.	10/3/07

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I 422	Continued From page 8	I 422		

direct care staff with dinner preparation. The direct care staff stepped away (approximately two feet) to put something in the trash can and the residentran upstairs to his bedroom. The staff pursued the residentup the stairs.

4:22 PM - Resident #4 removed the bed linens from his bed along with removing Clients #6 and #8's bed linens.

4:23 PM - Resident #4 was observed to be seated on resident#6's bed.

4:25 PM - Resident #4, along with a direct care staff, were observed to be seated on resident#8's bed. The residentwas instructed by the staff member to "sit on your hands."

4:26 PM - The direct care staff was overheard saying, "if you want to tear something, tear your shirt." The residentthen observed to tear his shirt.

4:30 PM - Resident #4, escorted by direct care staff came downstairs without wearing a shirt. The residentbegan to participate in tabletop activities (puzzles).

4:31 PM - Resident #4 was called to the dining table to receive his afternoon snack, without wearing a shirt. Resident #4 was without a shirt for 1 hour 55 minutes.

B. Interview with the direct care staff on September 11, 2007 at 5:55 PM, revealed that Resident #4 has a behavior of tearing his shirts and sometimes his pants. The resident must be monitored at all times, to avoid his behavior of shirt tearing. When the resident displays this behavior staff should provide the residentwith

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I 422	Continued From page 9 another shirt, although the residentwill tear it again. At 6:06 PM, the direct care staff provided the residentwith a shirt. C. Review of Resident #4's Behavior Support Plan (BSP) dated February 20, 2007 verified that the resident had the targeted behavior of clothes ripping. According to the BSP, the direct care staff should demonstrate the following strategies: - Involve the resident in activities which involve constructive use of his hands; - Praise him with social praise; - Once the resident displays the maladaptive behavior the direct care staff say, "[the client] do not tear your shirt and put your hand down; and - Immediately provide the resident with another article of clothing. Observations of this behavior during the survey failed to provide evidence that Resident #4's BSP was being implemented as outlined. 2. On September 11, 2007 during evening observations from 3:40 PM through 7:30 PM, Resident #4 was observed participating in table top activities (puzzles). Once the resident put a puzzle piece in place, the resident was observed hitting his chest or banging on the table. Interview with the direct care staff and Qualified Mental Retardation Professional (QMRP) on September 12, 2007 at approximately 11:00 AM revealed that the residenthad a BSP to address the client's chest hitting. Review of the BSP dated February 22, 2007 revealed a program objective which stated, "[the client] will reduce the	I 422	c 2. Staff in-service training on the current Behavior Support Plan was conducted on October 3, 2007. Follow-up training will be conducted as needed. Both the Psychologist and the QMRP will continue to monitor staff and give additional training as needed. QA & Program Manager will also monitor the above on routine basis. Attachment e1 + e2	10/3/07

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I 422	Continued From page 10 frequency of chest hitting to 20 reports per month for six months. According to the BSP, the direct care staff should demonstrate the following strategies: - Involve the resident in activities which involve constructive use of his hands; - Praise him with social praise and staff should clap their hands when praising the client. - the resident will be trained to clap his hand when he has done a good job; - Once the resident displays the maladaptive behavior the direct care staff say, "No [the client] do not hit your chest. Instruct the residentto clap his hands. Provide verbal prompts to hands on hand assistance as needed; and - Continue to reinforce the resident for appropriate behavior throughout the day. Observations of this behavior during the survey failed to provide evidence that Resident #4's BSP was being implemented as outlined. 3. The facility failed to implement Resident #4's speech program as written. On September 11, 2007 during evening observations from 3:40 PM through 7:30 PM, Resident #4 was observed participating in table top activities (puzzles). Once the resident put a puzzle piece in place, the residentwas observed hitting his chest or banging on the table. Interview with the direct care staff and Qualified	I 422	3- An in-service was done by Speech Pathologist on 10/01/07 on American Sign Language and communication goal of client # 4. QMRP will ensure the proper implementation of individual communication goal. Attachment P	10/1/07

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I 422	Continued From page 11 Mental Retardation Professional (QMRP) on September 12, 2007 at approximately 11:00 AM revealed that the residenthad a speech program to produce American sign language (ASL): good, drink, finished and game. The ASL "good" should be implemented as opposed hitting his chest or banging on the table. Review of the clients Individual Program Plan (IPP) dated February 2, 2007 revealed an objective which stated, "[the client] will produce four ASL sings "good, etc. . with 80% independence in one year December 2007. There was no evidence that the direct care staff implemented the strategies for Resident #4's speech program objective. 4. The facility failed to implement resident#4's activities of daily living skills. a. On September 11, 2007 at 4:31 PM, direct care staff was observed putting Resident #4's snack utensil in the kitchen sink. At 7:21 PM, direct care staff was again, observed putting the client's dinner plate, cup and utensils in the sink. Interview with the direct care staff indicated that the resident should be kept busy to avoid shirt tearing. Record review of the IPP dated February 2, 2007, Resident #4 has a program objective which states, "[the client] will place dinner ware to the kitchen sink on 80% of the trials recorded per month for three consecutive months. b. On September 11, 2007 during evening observations, the direct care staff was observed wiping the table, after both the snack and dinner meal. Interview with the direct care staff indicated that the residentshould be kept busy to	I 422 4. a i b	Client # 4 IPP goals and objectives will be implemented as written. Staff in-service was done on 10/02/07 to ensure consistent implementation of his programs. Above will be supervised by See Attachment F	10/2/07

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I 422	Continued From page 12 avoid shirt tearing. Record review of the IPP dated February 2, 2007, resident#4 has a program objective which states, "[the client] will wipe the table on 80% of the trials recorded per month for three consecutive months. There was no evidence that the facility encouraged resident#4 to participate in activities of daily living skills. II. The facility failed to ensure each clients IHP was being implemented in the form and frequency required. A. Interview with the Qualified Mental Retardation Professional (QMRP) on September 11, 2007 at 8:45 AM revealed Resident #1 was prescribed psychotropic medications and had a Behavior Support Plan (BSP) to address maladaptive behaviors. Review of the BSP (dated July 25, 2007) on September 13, 2007 at 5:34 PM revealed the plan had the following two program objectives: - Resident #1 will display no more than 15 reports of verbal aggression per month for 6 months. - Resident #1 will display no more than three occurrences of physical aggression (hitting others or objects) per month for 6 months. Further review of the plan revealed the plan incorporated the use of a report card system. According to the BSP, Resident#1 would review the report card every two hours with his primary counselor and the counselor would document the client's progress as it related to exhibiting any of	I 422	A- Staff In-service Training was conducted on October 3, 2007. Follow-up training will be conducted as needed. Both the Psychologist and QMRP will observe staff to determine if they are implementing the Behavior Support Plan as outlined, staff will be informed of appropriate support steps. Attachment C3	10/3/07

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I 422	Continued From page 13 the aforementioned targeted behaviors. For example, staff were required to ask the residentthe following questions every two hours: - Resident #1 did you keep your hands to yourself? - Resident #1 did you talk politely? - Resident #1 did you respect others property? After the resident responded to the questions (yes or no) staff would document either a 1 (referring to yes) of 0 (referring to no) onto the report card. The report card was scheduled to be completed from 4:00 PM to 9:00 PM weekdays and 7:00 AM to 9:00 PM on the weekends. If resident#1's report card documented 1's for at least 80% of the documentation on the previous day, the residentwas to receive "a magazine of his choice, a trip to a favorite place for a movie, shopping, etc...). Further review of the data collection record revealed there had been no documentation of resident#1's report card after August 3', 2007. It should be further noted that staff were not observed to utilize the report card system during the survey. At the time of the survey, the facility failed to provide evidence that Resident #1's BSP was being implemented as outlined. B. The facility failed to implement Resident #4's speech program as written. On September 11, 2007 during evening observations from 3:40 PM through 7:30 PM, Resident #4 was observed participating in table top activities (puzzles). Once the resident put a puzzle piece in place, the residentwas observed hitting his chest or banging on the table. Interview with the direct care staff and Qualified	I 422		

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	09G022	A. BUILDING _____ B. WING _____	09/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 422	Continued From page 14 Mental Retardation Professional (QMRP) on September 12, 2007 at approximately 11:00 AM revealed that the residenthad a speech program to produce American sign language (ASL): good, drink, finished and game. The ASL "good" should be implemented as opposed hitting his chest or banging on the table. Review of the clients Individual Program Plan (IPP) dated February 2 2007 revealed an objective which stated, "[the client] will produce four ASL sings "good, etc. . with 80% independence in one year December 2007. There was no evidence that the direct care staff implemented the strategies for Resident #4's speech program objective. C. The facility failed to implement Resident #4's activities of daily living skills. 1. On September 11, 2007 at 4:31 PM, direct care staff was observed putting Resident #4's snack utensil in the kitchen sink. At 7:21 PM, direct care staff was again, observed putting the client's dinner plate, cup and utensils in the sink. Interview with the direct care staff indicated that the residentshould be kept busy to avoid shirt tearing. Record review of the IPP dated February 2, 2007, Resident #4 has a program objective which states, "[the client] will place dinner ware to the kitchen sink on 80% of the trials recorded per month for three consecutive months. 2. On September 11, 2007 during evening observations, the direct care staff was observed wiping the table, after both the snack and dinner meal. Interview with the direct care staff indicated that the residentshould be kept busy to	I 422 B. C. 1 & 2.	An in-service was done by Speech Pathologist on 10/01/07 on American Sign Language and communication goal of client # 4. QMRP will ensure the proper implementation of individual communication goal. Attachment P Client # 4 IPP goals and objectives will be implemented as written. Staff in-service was done on 10/02/07 to ensure consistent implementation of his programs. Above will be supervised by See Attachment F	10-1-07 10-2-07

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I 422	Continued From page 15 avoid shirt tearing. Record review of the IPP dated February 2, 2007, Resident #4 has a program objective which states, "[the client] will wipe the table on 80% of the trials recorded per month for three consecutive months. There was no evidence that the facility encouraged Resident #4 to participate in activities of daily living skills.	I 422		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the habilitation and training of residents in the domain of self medication. The findings includes: See Federal Deficiency Report - Citations W371	I 436	Please see answer to W371	9-15-07
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:	I 437		

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I 437	Continued From page 16 (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide habilitation and training for one of the four residents included in the sample. (Resident #4) The finding includes: See Federal Deficiency Report - Citations W196, 3 and W249, 2	I 437	Please see answer to W-196-3 & W249-2-	10-3-07 10-1-07
I 472	3522.3 MEDICATIONS The physician who identifies the self-administration of medications as a goal for a resident shall develop and monitor the plan for implementation. This Statute is not met as evidenced by: Based on observations, interviews, and record review, the GHMRP failed to ensure the implementation of self-medication programs for residents The finding includes: See Federal Deficiency Report Citation W371	I 472	Please see answer to W371	9-15-07
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure	I 500		

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I 500	Continued From page 17 that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Standard is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each clients rights. The findings include: (See Federal Deficiency Report Citations W124, W263 and W264)	I 500	Please see answer to W124, W263 + W264.	10-4-07

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	09G022	A. BUILDING _____ B. WING _____	R 10/24/2007

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{W 000}	INITIAL COMMENTS The DC Health Care, Inc., Intermediate Care Facility is in compliance with 42 CFR Part 483, Subpart 1, requirements for Intermediate Care Facilities. A re-survey visit was conducted on October 24, 2007. This survey process focused on verifying compliance with federal and state requirements in the Conditions of Active Treatment. Seven males with varying degrees of disabilities reside in this facility. The survey sample was derived from a random sampling of four of the seven clients. The survey findings are based on observations in the group home. In addition, the findings are based on interviews with residential and administrative staff. Review of records; including investigations of unusual incidents was also conducted.	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{I 000}	INITIAL COMMENTS The DC Health Care, Inc., Intermediate Care Facility is in compliance 22 DCMR Chapter 35 requirements for Group Homes for the Mentally Retarded Persons (GHMRP)Intermediate Care Facilities. A re-survey visit was initiated and completed on October 24, 2007.	{I 000}		